

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6172 - CERTIFICATE OF DEATH

06112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Salisbury (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 2</b>		d. STREET ADDRESS <b>R.D.# 2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>ARNSPARGER</b> Last <b>ARNSPARGER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> th Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1877</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Clearspring, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Otho Hammond</b>		14. MOTHER'S MAIDEN NAME <b>Catherine -(unk)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Vaughn B. Arnsperger (Son) R.D.# 2 Salisbury, Maryland</b>	
17. INFORMANT <b>Mr. Vaughn B. Arnsperger (Son) R.D.# 2 Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Sudden</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/16</b> 19 <b>59</b> , to <b>5/11</b> 19 <b>59</b> , that I last saw the deceased alive on <b>5/11</b> 19 <b>59</b> , and that death occurred at <b>5:45 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Fred R. Gramse</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>5-11-1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b>		<b>S. Division St. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 14, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

# STATE OF NEW YORK DEPARTMENT OF HEALTH

IN COUNTY OF  
BOND

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6173 CERTIFICATE OF DEATH

Reg. Dist. No.

06113

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		c. LENGTH OF STAY IN 1b <b>5 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>TAYLOR</b> Last <b>B. ANKS</b>			4. DATE OF DEATH Month <b>5</b> Day <b>20</b> Year <b>19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1873</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>G eorge W. Taylor</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Ann Ingersoll</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b> <b>*****</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Raymond Keffel</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteroposterior Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Bronchitis Generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b> <b>10 Years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 March 1959</b> , to <b>20 May 1959</b> , that I last saw the deceased alive on <b>20 May 1959</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Richard H. Saunders</b> M.D. ADDRESS <b>Nanticoke Md.</b> DATE SIGNED <b>5/21/59</b> PHYSICIAN'S NAME (Type) <b>Richard H. Saunders</b> <b>NANTICOKE MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/22/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Siloam Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Siloam Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co.</b> <b>Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Name of physician

8. Name of informant

9. Signature of informant

10. Name of registrar

11. Name of witness

12. Signature of witness

13. Name of funeral home

14. Name of cemetery

15. Signature of funeral home

16. Name of registrar

17. Name of witness

18. Signature of witness

19. Name of registrar

20. Name of witness

21. Signature of witness

22. Name of registrar

23. Name of witness

24. Signature of witness

25. Name of registrar

26. Name of witness

27. Signature of witness

28. Name of registrar

29. Name of witness

30. Signature of witness

31. Name of registrar

32. Name of witness

33. Signature of witness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6115 CERTIFICATE OF DEATH

06114

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARDELA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>HAROLD MCKINLEY Bennett</u>			<b>4. DATE OF DEATH</b>		Month <u>May</u> Day <u>19</u> Year <u>1959</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARDELA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>JOHN P. BENNETT</u>			
14. MOTHER'S MAIDEN NAME <u>MAUD SEABREASE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>W-1</u>				17. INFORMANT <u>Virginia Bennett - Mardele Md</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, Rt. Lung</u> 331x DUE TO (b) <u>Old cerebrovascular Accident &amp; Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>59</u> , to <u>May 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>59</u> , and that death occurred at <u>5:10</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr., M.D.</u>				ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>5/19/59</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mardele</u>		22d. LOCATION (City, town, or county) (State) <u>Mardele Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Mardele Co. Selma Sel</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>MAIN ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John</u> <u>Benton</u>				4. DATE OF DEATH Month Day Year <u>5-</u> <u>30-</u> <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT-18-1887</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ARCHIE W. BENTON</u>				14. MOTHER'S MAIDEN NAME <u>MOLLIE WEBSTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-20-9271A</u>		17. INFORMANT <u>JOHN A. BENTON - SON - DEAL ISLAND MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive cardio-vascular disease</u> (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>Years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-31-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 3-1959</u>		22c. NAME OF CEMETERY <u>ST. JOHN'S</u>		22d. LOCATION (City, town, or county) (State) <u>DEAL ISLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. J. Webster - Deal Island Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraser</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Burial Society		17. Signature of Burial Society		18. Signature of Burial Society	
19. Signature of Burial Society		20. Signature of Burial Society		21. Signature of Burial Society	
22. Signature of Burial Society		23. Signature of Burial Society		24. Signature of Burial Society	
25. Signature of Burial Society		26. Signature of Burial Society		27. Signature of Burial Society	
28. Signature of Burial Society		29. Signature of Burial Society		30. Signature of Burial Society	
31. Signature of Burial Society		32. Signature of Burial Society		33. Signature of Burial Society	
34. Signature of Burial Society		35. Signature of Burial Society		36. Signature of Burial Society	
37. Signature of Burial Society		38. Signature of Burial Society		39. Signature of Burial Society	
40. Signature of Burial Society		41. Signature of Burial Society		42. Signature of Burial Society	
43. Signature of Burial Society		44. Signature of Burial Society		45. Signature of Burial Society	
46. Signature of Burial Society		47. Signature of Burial Society		48. Signature of Burial Society	
49. Signature of Burial Society		50. Signature of Burial Society		51. Signature of Burial Society	
52. Signature of Burial Society		53. Signature of Burial Society		54. Signature of Burial Society	
55. Signature of Burial Society		56. Signature of Burial Society		57. Signature of Burial Society	
58. Signature of Burial Society		59. Signature of Burial Society		60. Signature of Burial Society	
61. Signature of Burial Society		62. Signature of Burial Society		63. Signature of Burial Society	
64. Signature of Burial Society		65. Signature of Burial Society		66. Signature of Burial Society	
67. Signature of Burial Society		68. Signature of Burial Society		69. Signature of Burial Society	
70. Signature of Burial Society		71. Signature of Burial Society		72. Signature of Burial Society	
73. Signature of Burial Society		74. Signature of Burial Society		75. Signature of Burial Society	
76. Signature of Burial Society		77. Signature of Burial Society		78. Signature of Burial Society	
79. Signature of Burial Society		80. Signature of Burial Society		81. Signature of Burial Society	
82. Signature of Burial Society		83. Signature of Burial Society		84. Signature of Burial Society	
85. Signature of Burial Society		86. Signature of Burial Society		87. Signature of Burial Society	
88. Signature of Burial Society		89. Signature of Burial Society		90. Signature of Burial Society	
91. Signature of Burial Society		92. Signature of Burial Society		93. Signature of Burial Society	
94. Signature of Burial Society		95. Signature of Burial Society		96. Signature of Burial Society	
97. Signature of Burial Society		98. Signature of Burial Society		99. Signature of Burial Society	
100. Signature of Burial Society		101. Signature of Burial Society		102. Signature of Burial Society	



## CERTIFICATE OF DEATH

Reg. Dist. No.

06116

6117

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond Maurice Carey</u>		4. DATE OF DEATH <u>May 5 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Game Warden</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Conservation</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Everett Joshua Carey</u>		14. MOTHER'S MAIDEN NAME <u>Jennie LeCompte</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Raymond Carey, Sr.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>5-5</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>5-5-59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-8-59</u>	<u>Manokin Presbyterian</u>	<u>Princess Anne, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		24. REC'D BY REGISTRAR <u>DATE MAY 11 '59</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6118 CERTIFICATE OF DEATH

06117

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>43 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b> (Previously a resident of Kent County)		d. STREET ADDRESS <b>Everett Nursing Home</b> 14X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eli</b> Middle <b>Perry</b> Last <b>Cranor</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/1868</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>River Boats Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eli Perry Cranor</b>		14. MOTHER'S MAIDEN NAME <b>Ann Shelton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Informant Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive heart failure</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Intertrochanteric fracture of right side</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 30</b> , 19 <b>59</b> , to <b>May 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>59</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Kosmahly</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>5/13/59</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

UNITED STATES DEPARTMENT OF AGRICULTURE

Washington, D. C.

June 1, 1906

Dear Sir:

Very much interested

in your letter

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Items 18-21 Film 242 5-22-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 06118

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joe</u> Middle <u>Daniels</u> Last <u>Daniels</u>		4. DATE OF DEATH Month <u>5-</u> Day <u>12-</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>44</u> Days <u>44</u>	11. IF UNDER 24 HRS. Hours <u>44</u> Min. <u>44</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	11. BIRTHPLACE (State or foreign country) <u>Georgia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Willie Daniels</u>	
14. MOTHER'S MAIDEN NAME <u>Cornelia Irwin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>265-07-8389</u>		17. INFORMANT Address <u>Pearl Fulton, Newark, N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Methyl Alcohol Poisoning</u> DUE TO <u>Chronic Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Alcoholism</u> (c) <u>Chronic Alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>880.0</u> hours <u>880.0</u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ingested Methyl alcohol</u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>5-11</u> p. m. <u>19 59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acre Cemetery</u>
		22d. LOCATION (City, town, or county) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>FUNERAL HOME - Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Hanks</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - FORM 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH		10-11-19	
1. NAME OF DECEASED JAMES J. JONES		2. SEX Male	
3. AGE 45		4. DATE OF DEATH 10-10-19	
5. PLACE OF DEATH Home		6. OCCUPATION Teacher	
7. MARITAL STATUS Married		8. EDUCATION High School	
9. RELIGION Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF EXAMINER [Signature]		14. SIGNATURE OF DECEASED [Signature]	
15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF DECEASED [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF DECEASED [Signature]	
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## 6120 CERTIFICATE OF DEATH

06119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>20 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D.O.A. Pen.Gen. Hospital</b>				d. STREET ADDRESS <b>919 Russell Ave.,</b>			
3. NAME OF DECEASED (Type or print) <b>MARGARET RAWLINGS DAVIS</b>				4. DATE OF DEATH Month <b>5</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1894</b>	9. AGE (In years last birthday) yrs. <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Wm. S/ Rawlings</b>				14. MOTHER'S MAIDEN NAME <b>Jane Morton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. E.D.O. Davis, Jr. Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Complete heart block</b> DUE TO (c) <b>Ch. Arteriosclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>5-1</b> , 19 <b>59</b> , and that death occurred at <b>11:50 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip A. Insley</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>		DATE SIGNED <b>5/4/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley 116 East Main St., Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

Norman F. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00119

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES H. DAVIS		SEX Male		AGE 35		DATE OF BIRTH 1888		PLACE OF BIRTH Maryland	
OCCUPATION Farmer		EDUCATION High School		MARRIAGE Married		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE Maryland	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS 2 weeks		DATE OF DEATH 1923		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. H. Davis		SIGNATURE OF WITNESSES J. H. Davis, J. H. Davis		SIGNATURE OF DECEASED J. H. Davis		SIGNATURE OF NEAREST RELATIVE J. H. Davis		SIGNATURE OF CLERK J. H. Davis	
LOCAL HEALTH OFFICER J. H. Davis		COUNTY HEALTH OFFICER J. H. Davis		STATE HEALTH OFFICER J. H. Davis		FEDERAL HEALTH OFFICER J. H. Davis		REMARKS None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)  
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06120

6121 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>30 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Route # 1</b>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Ellen</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Monie, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Tubman Heath</b>		14. MOTHER'S MAIDEN NAME <b>Hopkins Sarah Hopkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Informant</b> Address <b>Hospital Records, Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial insufficiency</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 22</b> , 19 <b>59</b> , to <b>May 22</b> , 19 <b>59</b> , that I lost s/he the deceased on <b>May 22</b> , 19 <b>59</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>5/22/59</b>			
ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D.		PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b> <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grace Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Vernon, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Harrison</b> ADDRESS <b>Princess Anne Md</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Farris</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6122 CERTIFICATE OF DEATH

06121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>211 Tilghman St</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>211 Tilghman St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>PRETTIMAN</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>th 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Truck Body Builder-Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.D.# Barsonsburg, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Levin J. Davis</b>		14. MOTHER'S MAIDEN NAME <b>Joanna Truitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unk</b>	
17. INFORMANT <b>Mrs. Gertrude M. Davis (Wife)</b>		Address <b>211 Tilghman St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> <b>420.1</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> (c) <b>Coronary arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic heart disease &amp; decompensation - chronic bronchitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 25</b> , 19 <b>57</b> , to <b>May 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 25</b> , 19 <b>57</b> , and that death occurred at <b>7:10 A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>303 East Street Delmar Md.</b> DATE SIGNED <b>5-27-57</b>	
ACTUAL SIGNATURE <b>L.V. Sohler</b> M.D.		PHYSICIAN'S NAME (Type) <b>L.V. Sohler</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 30, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Gardens - Salisbury, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlino S. Kneass</b>	





6123 CERTIFICATE OF DEATH

Reg. Dist. No.

06122

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>ROUTE # 2</u>			
3. NAME OF DECEASED (Type or print) First <u>VANESSA</u> Middle <u>Dennis</u> Last <u>Dennis</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-18-1959</u>	
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u>6</u>		IF UNDER 24 HRS. Days <u>6</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ROLUS DENNIS</u>				14. MOTHER'S MAIDEN NAME <u>BEATRICE MANUEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>                    </u>		17. INFORMANT Address <u>ROLUS DENNIS, Snow Hill, Md, Rt #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 650 gms.)</u> 776x DUE TO (b) <u>                    </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>                    </u> DUE TO (b) <u>                    </u> (c) <u>                    </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>                    </u> p. m. <u>                    </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/19/59</u> , 19 <u>59</u> , to <u>5/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>59</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Alfred C. Kolls</u>				DATE SIGNED <u>                    </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOME BENEFICIAL Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u> ADDRESS <u>FUNERAL HOME, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

2082306XVO

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06123

## 6124 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b> <b>46 X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula Gen. Hospital</b>		d. STREET ADDRESS <b>W. State Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Samuel Richard Disharoon</b>		4. DATE OF DEATH Month Day Year <b>May 3rd 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1909</b>
9. AGE (In years, lost birthday) <b>49</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Disharoon</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-12-5355</b>	
17. INFORMANT <b>Ellen Disharoon, Del.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage with general paralysis</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiac vascular disease</b> DUE TO (c) <b>Stroke</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 27</b> , 19 <b>58</b> , to <b>May 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 3</b> , 19 <b>59</b> , and that death occurred at <b>M</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. H. Lyndeb</b>		DATE SIGNED <b>May 4 - 59</b>	
PHYSICIAN'S NAME (Type) <b>S. H. Lyndeb</b>		ADDRESS (Street, city or town, state) <b>Delmar Del</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-6-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury Del</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Garrel Co - Delmar, Del</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAY 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Office of registration: _____</p>	

RECEIVED  
BALTIMORE  
MAY 10 1918

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6125

## CERTIFICATE OF DEATH

06124

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>since 3/16/59</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westover</u>		<u>19x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u>				STREET ADDRESS (if rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ESTHER GERTRUDE DOANE</u> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>May 29 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>July 5, 1894 (?)</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Diner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Miles</u>				14. MOTHER'S MAIDEN NAME <u>Esther Terpin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>002X Pulmonary tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>3/16</u> , 19 <u>59</u> , to <u>5/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/29</u> , 19 <u>59</u> , and that death occurred at <u>4:10 p.m.</u> from the causes and on the date stated above. SIGNATURE <u>Edward P. Ritchie</u> ADDRESS <u>Pine Bluff Hosp. Salisbury, Md.</u> DATE SIGNED <u>5/29/59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/11/59</u>		NAME OF CEMETERY OR CREMATORY <u>College Grove Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westover, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 4 '59</u>		REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James</u> ADDRESS <u>Frederick, Md.</u>			

1 hours after death.

# SHORT NOTICE

NOTICE TO THE PUBLIC: This is to certify that the following is a true and correct copy of the original as filed in the office of the County Clerk of the County of Cook, Illinois, on the 1st day of January, 1900.

## CERTIFICATE OF DEATH

STATE OF ILLINOIS - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>		<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>	
<p>RESIDENCE</p>		<p>CAUSE OF DEATH</p>		<p>IMMEDIATE CAUSE</p>		<p>INTERMEDIATE CAUSE</p>		<p>PREEXISTING DISEASE</p>		<p>PERIOD OF ILLNESS</p>		<p>TIME OF DEATH</p>		<p>TIME OF BURIAL</p>	
<p>NAME OF PHYSICIAN</p>		<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>		<p>NAME OF BURIAL PLACE</p>		<p>NAME OF CEMETERY</p>		<p>NAME OF CITY</p>		<p>NAME OF COUNTY</p>		<p>NAME OF STATE</p>	



## 6126 CERTIFICATE OF DEATH

06125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Slate</u> Middle <u>---</u> Last <u>Duck</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 31, 1883</u>		9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Timber Cutting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>Windsor, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Mills Duck</u>				14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		INFORMANT <u>Mrs. Callie Duck (Wife) R.D.# 1</u> <u>Hospital Records --/Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure due to</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerosis, General</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>  <u>?</u>  <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/17/</u> 19 <u>59</u> , to <u>5/1/</u> 19 <u>59</u> , that I last saw the deceased alive on <u>5/1/59</u> , 19 <u>59</u> , and that death occurred at <u>5:40 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>5/2/59</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>				Deer's Head State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

00125

ASSOCIATION OF CHURCHES

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
6M 2/57

6127

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> 23x-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rena</u> Middle <u>Elliott</u> Last <u>Elliot</u>				4. DATE OF DEATH Month <u>5-</u> Day <u>7-</u> Year <u>19 59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-15-1904</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Smith</u>				14. MOTHER'S MAIDEN NAME <u>MARION ? Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>John Elliott, Berlin, Md, Box 171</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage-right.</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive heart disease.</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-10-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bural</u>		22b. DATE THEREOF <u>5-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Stewart</u>				24a. REC'D BY REGISTRAR <u>MAY 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION

2

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M

1. Name of Deceased: WILLIAM J. BROWN

2. Sex: Male

3. Age: 45

4. Date of Birth: 1910

5. Place of Birth: NEW YORK

6. Usual Residence: 123 Main St, New York

7. Date of Death: 1955

8. Time of Death: 10:00 AM

9. Place of Death: Home

10. Cause of Death: Heart Disease

11. Manner of Death: Natural

12. Signature of Medical Examiner: [Signature]

13. Date of Examination: 1955

14. Signature of Coroner: [Signature]

15. Date of Filing: 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6128 CERTIFICATE OF DEATH

06127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>EVANS</u> Last <u>EVANS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 29, 1959</u>
9. AGE (In years last birthday) <u>14</u>		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Evans</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Reynolds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>---</u>	
17. INFORMANT <u>Lawrence Evans</u>		Address <u>Berlin Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrops fetalis</u> DUE TO <u>Rh antibody sensitivity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>9:25 PM, 5/29/59</u> to <u>9:25 PM 5/29/59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert Lee Baker M.D.</u>		ADDRESS (Street, city or town, state) <u>---</u>	
PHYSICIAN'S NAME (Type) <u>---</u>		DATE SIGNED <u>---</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Gubage</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 and 2 with the registrar prior to burial, cremation, or removal.

6129

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06128

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL</u>			d. STREET ADDRESS <u>1 N. Salisbury Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alton</u> Middle <u>E</u> Last <u>Fields</u>			4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1904</u>	9. AGE (In years, last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>	
13. FATHER'S NAME <u>Lee C. Fields</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>			14. MOTHER'S MAIDEN NAME <u>Annie Bounds</u>		
16. SOCIAL SECURITY NO. <u></u>			17. INFORMANT <u>Mrs. Elinor B. Phillips (Step-Sister) 1019 1/2 N. Division St Salisbury, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Aneurysm</u> <u>420.0</u> DUE TO <u>Arterio Sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> (b) <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>year</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-22-59</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	
22d. LOCATION (City, town, or county)		22e. (State)		22f. (City, town, or county)	
22g. (State)		22h. (City, town, or county)		22i. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>		24c. (City, town, or county)		24d. (State)	



## 6174 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>				c. LENGTH OF STAY IN 1b <u>69 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phillip Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George R. Ford</u>				4. DATE OF DEATH Month Day Year <u>May 26 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1890</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>George R. Ford</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Kattie Ford Phillip Avenue Hebron Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 March 1959</u> to <u>26 May 1959</u> , that I last saw the deceased alive on <u>26 May 1959</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Phillip Avenue Hebron Md.</u> <u>29 May 59</u>							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.		PHYSICIAN'S NAME (Type) <u>Richard H. Saunders Nanticoke Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clinton F. Stewart Salisbury Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6130

## CERTIFICATE OF DEATH

Reg. Dist. No.

06130

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Rumley 19x-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ovid</u> Middle <u>F.</u> Last <u>FRENCH</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 18 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u> Hours <u>5</u> Min. <u>10</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maybloss</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John F. French</u>				14. MOTHER'S MAIDEN NAME <u>Hester H. Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				18. SOCIAL SECURITY NO. <u>INFORMANT</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-11-1959</u> to <u>5-3-1959</u> , that I last saw the deceased alive on <u>5-2-1959</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>5-3-59</u>							
ACTUAL SIGNATURE <u>William B. Ellis Jr.</u> M.D. <u>Salisbury, Md.</u>							
PHYSICIAN'S NAME (Type) <u>William B. Ellis Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-6-59</u>		<u>Farmington Cemetery</u>		<u>Farmington Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Nelson</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>MAY 6 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11130

CERTIFICATE OF DEATH

11130

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06131

6175

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD # 3</b>				d. STREET ADDRESS <b>RFD # 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Edward</b> Last <b>Glackin</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1906</b>		9. AGE (In years lost birthday) yrs. <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Lee Glackin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WW 1 140-24-5688</b>		17. INFORMANT <b>Regis Glackin, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoparathyroidism and anemia</b> <b>202.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Reticulum cell Sarcoma - generalized</b> DUE TO (c) <b>metastases - origin skin or subcutaneous, leg.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March, 1959</b> , to <b>death</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Apr. 27</b> , 19 <b>59</b> , and that death occurred at <b>3:51 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>100 Grove Street, Delmar, Del.</b> DATE SIGNED <b>5/13/59</b>							
ACTUAL SIGNATURE <b>Ernest M. Larmore</b>		M.D. <b>100 Grove Street</b>		DATE SIGNED <b>5/13/59</b>			
PHYSICIAN'S NAME (Type) <b>Ernest M. Larmore</b>		<b>Delmar, Delaware</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-16-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Marvel Co - Delmar, Del.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 15 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

CERTIFICATE OF DEATH

FILE

DATE

TIME

PLACE

CAUSE

DEATH

1900-1901

1902-1903

1904-1905

1906-1907

1908-1909

1910-1911

1912-1913

1914-1915

1916-1917

1918-1919

1920-1921

1922-1923

1924-1925

1926-1927

1928-1929

1930-1931

1932-1933

1934-1935

1936-1937

1938-1939

6131

CERTIFICATE OF DEATH

Reg. Dist. No.

06132

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 17</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anderson</b> Middle <b>--</b> Last <b>Graves</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1901</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>--</b>	
INFORMANT Address <b>Deer's Head State Hospital, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral subarachnoid hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 6,</b> 19 <b>59</b> , to <b>May 7,</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 7,</b> 19 <b>59</b> , and that death occurred at <b>7:45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>5/7/59</b>			
ACTUAL SIGNATURE <b>V. Juerman</b>		M.D. <b>Deer's Head State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>5.11.59</b>	22c. NAME OF CEMETERY OR CREMATOR <b>V. Juerman Med. School</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE <b>MAY 12 '59</b>		<b>Arthur S. Kline</b>	

091

I

MEDICAL CERTIFICATION

IN SENATE  
JANUARY 11 1812

REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN ANSWER TO A  
RESOLUTION PASSED  
BY THE SENATE  
MAY 18 1811  
RELATIVE TO THE  
LANDS BELONGING  
TO THE STATE



ALBANY: J. B. LEECH, 1812.

Printed by J. B. LEECH, at the Office of the  
Commissioners of the Land Office.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6176 Item 2 Film 6243 6-3-59 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

06133

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Delmar</u>		c. LENGTH OF STAY IN 1b <u>9 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Holloway Nursing Home</u>		d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>H.</u> Last <u>HAYMAN</u>		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/1865</u>
9. AGE (In years less birthday) yrs. <u>94</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retard Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>WILLIAM HAYMAN</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE WINDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>HENNETTA HAYMAN, PRINCESS ANNE, MD</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent lobar pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>2-11, 1959</u> , to <u>death</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>59</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest M. Larmore</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>100 Grove St. 5/26/59</u>	
PHYSICIAN'S NAME (Type) <u>Ernest M. Larmore</u>		<u>Delmar, Delaware</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr</u>		ADDRESS <u>Princess Anne, md</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	





# 6132 CERTIFICATE OF DEATH

Reg. Dist. No.

06134

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia 24 75 x-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>				d. STREET ADDRESS <b>1239 ADAMS AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>CLARA</b> Last <b>HERCKER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 28, 1890</b>	9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Laurel Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>David H. Waller</b>				14. MOTHER'S MAIDEN NAME <b>Amelia E. Marvel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Mrs. Mary Shivers (Daughter) 1239 Adams Ave. Phila. 24, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Embolus.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 18 19 59</b> to <b>May 31 19 59</b> that I last saw the deceased alive on <b>May 31 19 59</b> , and that death occurred at <b>11:40 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Carrie Hearn</b>			M.D. <b>226 N. Division St.</b>		DATE SIGNED <b>June 1 1959</b>		
PHYSICIAN'S NAME (Type) <b>Dr. Carrie I. Hearn</b>			226 N. Division St. Salisbury, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jun. 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Sepulcher Cemetery-Wyndmoor, Montgomery Co.</b>		22d. LOCATION (City, town, or county) (State) <b>Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hearn</b>			

MEDICAL CERTIFICATION

082

1



6133

# CERTIFICATE OF DEATH

Reg. Dist. No.

06135

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>		d. STREET ADDRESS <u>Snow Hill</u>	
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>H.</u> Last <u>Jarman</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11 - 1878</u>
9. AGE (In years last birthday) <u>81-1-12</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Berlin, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mathias Brittingham</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Jarman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mustarry H. Jones, 4177 N.W. 91 St., Miami 50, Florida</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 420.1 DUE TO (b) <u>Coronary Artery plant disease</u> DUE TO (c) <u>Coronary Atherosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Interval between onset and death 2 months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 24</u> , 19 <u>59</u> , to <u>May 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 23</u> , 19 <u>59</u> , and that death occurred at <u>6:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alvin J. Gilmore</u>		DATE SIGNED <u>May 23, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Blay E. Harris</u>		ADDRESS <u>Snow Hill, md</u>	
22a. MANNER OF REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>May 26/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Methodist</u>		22d. LOCATION (City, town or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blay E. Harris</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 6134 CERTIFICATE OF DEATH

06136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>19X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Eretha</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 15 1880</u>		9. AGE (In years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Eben Murray</u>				14. MOTHER'S MAIDEN NAME <u>Mary Austin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Lois Jackson Princess Anne Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYSEPTIC THROMBOSIS</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MAY 7</u> , 19 <u>59</u> , to <u>MAY 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 10</u> , 19 <u>59</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>John M. Bloxom III</u>				M.D. <u>Salisbury Md May 10 1959</u>			
PHYSICIAN'S NAME (Type) <u>JOAN M. BLOXOM</u>				<u>SALISBURY, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/12/59</u>		<u>Asbury</u>		<u>Met Vernon Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hannon</u>				ADDRESS <u>Princess Anne Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 18 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hannon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00135

2000-01-01

1914

1914 Jan 1 1914

John L. Smith

Age 45

Married

John L. Smith

John L. Smith

John L. Smith

John L. Smith

John L. Smith

John L. Smith

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John L. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 1,8,9 Film 6243 5-26-59 et  
6135  
CERTIFICATE OF DEATH

Reg. Dist. No.

06137

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>22 Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>613 Pearl St. home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fulton</u> Middle <u>S.</u> Last <u>Jolley</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1889</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David S. Jolley</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs. Ada Jolley</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Vienna</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO <u>Pneumonia</u> (c) <u>Atherosclerosis</u> DUE TO <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Indefinite</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 Jan, 1959</u> to <u>7 May 1959</u> , that I last saw the deceased alive on <u>7 May</u> , 19 <u>59</u> and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>613 Pearl St. Salisbury Md.</u> DATE SIGNED <u>11 May 59</u>	
PHYSICIAN'S NAME (Type) <u>E A Purnell M.D.</u>		<u>Salisbury Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>5/11/59</u>	<u>Green Acres Cem.</u>	<u>Salisbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>MAY 19 59</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

# CERTIFICATE OF DEATH

37

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 6 Film G243 6-2-59 et

6177

CERTIFICATE OF DEATH

06138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Princess Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Princess Anne</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pesterville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pesterville</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>L.</u> Last <u>Lewis</u> (Last)				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 22 1888</u>			
9. AGE (In years last birthday) <u>67</u> yrs.		10. UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>19</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>					
13. FATHER'S NAME <u>Jesse Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Lewis</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>					
17. INFORMANT <u>Rose Lewis</u>				Address <u>Pesterville Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>5 years</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>8 May 1959</u> to <u>19 May 1959</u> , that I last saw the deceased alive on <u>19 May 1959</u> , and that death occurred at <u>12 A.</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Richard H Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u>					
DATE SIGNED <u>5/20/59</u>				PHYSICIAN'S NAME (Type) <u>RICHARD H SAUNDERS</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pesterville Cem.</u>		22d. LOCATION (City, town, or county) <u>Pesterville Md.</u> (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilson</u>				ADDRESS <u>Princess Anne</u>		24a. REC'D BY REGISTRAR <u>May 26 '59</u> DATE			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>									

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>10/15/1918</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. RELIGION <i>Methodist</i>		14. COLOR <i>White</i>		15. BUILD <i>Medium</i>	
16. HABIT <i>None</i>		17. ALCOHOLIC <i>None</i>		18. TOBACCO <i>None</i>	
19. PREVIOUS ILLNESS <i>None</i>		20. PREVIOUS SURGERY <i>None</i>		21. PREVIOUS TRAUMA <i>None</i>	
22. PREVIOUS INJURY <i>None</i>		23. PREVIOUS FEVER <i>None</i>		24. PREVIOUS CONVULSIONS <i>None</i>	
25. PREVIOUS EPILEPSY <i>None</i>		26. PREVIOUS PARALYSIS <i>None</i>		27. PREVIOUS STROKE <i>None</i>	
28. PREVIOUS TUBERCULOSIS <i>None</i>		29. PREVIOUS PNEUMONIA <i>None</i>		30. PREVIOUS BRONCHITIS <i>None</i>	
31. PREVIOUS ASTHMA <i>None</i>		32. PREVIOUS GOUT <i>None</i>		33. PREVIOUS RHEUMATISM <i>None</i>	
34. PREVIOUS SCURVY <i>None</i>		35. PREVIOUS SYPHILIS <i>None</i>		36. PREVIOUS GOITRE <i>None</i>	
37. PREVIOUS DIABETES <i>None</i>		38. PREVIOUS HYPERTENSION <i>None</i>		39. PREVIOUS ANEMIA <i>None</i>	
40. PREVIOUS LEUKEMIA <i>None</i>		41. PREVIOUS LYMPHOMA <i>None</i>		42. PREVIOUS SARCOMA <i>None</i>	
43. PREVIOUS CARCINOMA <i>None</i>		44. PREVIOUS MELANOMA <i>None</i>		45. PREVIOUS OSTEOGENOMA <i>None</i>	
46. PREVIOUS OSTEOID <i>None</i>		47. PREVIOUS OSTEOCLASTOMA <i>None</i>		48. PREVIOUS OSTEOBLASTOMA <i>None</i>	
49. PREVIOUS OSTEOID <i>None</i>		50. PREVIOUS OSTEOCLASTOMA <i>None</i>		51. PREVIOUS OSTEOBLASTOMA <i>None</i>	
52. PREVIOUS OSTEOID <i>None</i>		53. PREVIOUS OSTEOCLASTOMA <i>None</i>		54. PREVIOUS OSTEOBLASTOMA <i>None</i>	
55. PREVIOUS OSTEOID <i>None</i>		56. PREVIOUS OSTEOCLASTOMA <i>None</i>		57. PREVIOUS OSTEOBLASTOMA <i>None</i>	
58. PREVIOUS OSTEOID <i>None</i>		59. PREVIOUS OSTEOCLASTOMA <i>None</i>		60. PREVIOUS OSTEOBLASTOMA <i>None</i>	
61. PREVIOUS OSTEOID <i>None</i>		62. PREVIOUS OSTEOCLASTOMA <i>None</i>		63. PREVIOUS OSTEOBLASTOMA <i>None</i>	
64. PREVIOUS OSTEOID <i>None</i>		65. PREVIOUS OSTEOCLASTOMA <i>None</i>		66. PREVIOUS OSTEOBLASTOMA <i>None</i>	
67. PREVIOUS OSTEOID <i>None</i>		68. PREVIOUS OSTEOCLASTOMA <i>None</i>		69. PREVIOUS OSTEOBLASTOMA <i>None</i>	
70. PREVIOUS OSTEOID <i>None</i>		71. PREVIOUS OSTEOCLASTOMA <i>None</i>		72. PREVIOUS OSTEOBLASTOMA <i>None</i>	
73. PREVIOUS OSTEOID <i>None</i>		74. PREVIOUS OSTEOCLASTOMA <i>None</i>		75. PREVIOUS OSTEOBLASTOMA <i>None</i>	
76. PREVIOUS OSTEOID <i>None</i>		77. PREVIOUS OSTEOCLASTOMA <i>None</i>		78. PREVIOUS OSTEOBLASTOMA <i>None</i>	
79. PREVIOUS OSTEOID <i>None</i>		80. PREVIOUS OSTEOCLASTOMA <i>None</i>		81. PREVIOUS OSTEOBLASTOMA <i>None</i>	
82. PREVIOUS OSTEOID <i>None</i>		83. PREVIOUS OSTEOCLASTOMA <i>None</i>		84. PREVIOUS OSTEOBLASTOMA <i>None</i>	
85. PREVIOUS OSTEOID <i>None</i>		86. PREVIOUS OSTEOCLASTOMA <i>None</i>		87. PREVIOUS OSTEOBLASTOMA <i>None</i>	
88. PREVIOUS OSTEOID <i>None</i>		89. PREVIOUS OSTEOCLASTOMA <i>None</i>		90. PREVIOUS OSTEOBLASTOMA <i>None</i>	
91. PREVIOUS OSTEOID <i>None</i>		92. PREVIOUS OSTEOCLASTOMA <i>None</i>		93. PREVIOUS OSTEOBLASTOMA <i>None</i>	
94. PREVIOUS OSTEOID <i>None</i>		95. PREVIOUS OSTEOCLASTOMA <i>None</i>		96. PREVIOUS OSTEOBLASTOMA <i>None</i>	
97. PREVIOUS OSTEOID <i>None</i>		98. PREVIOUS OSTEOCLASTOMA <i>None</i>		99. PREVIOUS OSTEOBLASTOMA <i>None</i>	
100. PREVIOUS OSTEOID <i>None</i>		101. PREVIOUS OSTEOCLASTOMA <i>None</i>		102. PREVIOUS OSTEOBLASTOMA <i>None</i>	

1

## 6136 CERTIFICATE OF DEATH

Reg. Dist. No.

06139

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE JOHN LENNART</u>				4. DATE OF DEATH Month Day Year <u>MAY 6 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 26, 1892</u>		9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Mgr/ Gas Pumps. Wayne Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. J. Lennart</u>				14. MOTHER'S MAIDEN NAME <u>Belle Morton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>306-05-6315</u>		INFORMANT Address <u>Mrs. Helen L. Lennart, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma lung &amp; widespread</u> DUE TO (c) <u>metastasis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>54</u> , to <u>5/6/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/6/59</u> , 19 <u>59</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.C. Mitchell</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>5/6/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. A.C. Mitchell 211 Maryland Ave., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Wayne, Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u> <u>Norman F. Baker</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07139

U.S. DEPARTMENT OF HEALTH

Married

Belmont

Wm. H. Belmont

1900

Belmont

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Belmont

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Belmont

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Belmont



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6137

## CERTIFICATE OF DEATH

06140

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>23x-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>Bishop</b>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>LEWIS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 20-</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>0</b> Hours <b>0</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTH PLACE (State or foreign country) <b>Salisbury, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unk</b>		14. MOTHER'S MAIDEN NAME <b>Billie Mae Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Mrs. Ella C. Lewis (Grand-Mother)</b>		18. ADDRESS <b>Bishop, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Prematurity (IV+ 650 gms)</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1. 3 longitudinal absence of multiple digits of hands</b> <b>2. Diaphragmatic hernia, fetal type, immature</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 May 1959</b> , to <b>21 May 1959</b> , that I last saw the deceased alive on <b>21 May 1959</b> , and that death occurred at <b>10:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Robert W. Sanderson</b>		DATE SIGNED <b>5/21/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Robert W. Sanderson</b>		ADDRESS (Street, city or town, state) <b>Salisbury Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 22, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>MAY 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

# CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

## 6138 CERTIFICATE OF DEATH

Reg. Dist. No. 06141

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Accomac</u> STATE <u>VIRGINIA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAXIS VA.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>83X-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS NEAT Lewis</u>		4. DATE OF DEATH Month Day Year <u>May 4 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 8th 73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>	
11. BIRTHPLACE (State or foreign country) <u>SAN FORD, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>SAITHA Lewis</u>		14. MOTHER'S MAIDEN NAME <u>DOLLIE Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>137-10-1572</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-12</u> , 1959, to <u>5-4</u> , 1959, that I last saw the deceased alive on <u>5-4</u> , 1959, and that death occurred at <u>5:35</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>5-4-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Downing's</u>		22d. LOCATION (City, town, or county) (State) <u>OAK HALL, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FOX FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6178 CERTIFICATE OF DEATH

Reg. Dist. No.

06142

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Haven</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Haven</b>	
		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Long</b> Last		4. DATE OF DEATH Month <b>5</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8/15/1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>13</b> Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Richard Long</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ellen Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>146-10-2731</b>	
17. INFORMANT <b>Mrs Edward Burke, White Haven, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease - Acute</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>pulmonary edema</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>58</b> , to <b>5/28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/27/59</b> , 19 <b>59</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Alberta Mattox</b>		ADDRESS (Street, city or town, state) <b>711 Camden Ave</b>	
PHYSICIAN'S NAME (Type) <b>C. S. Messick</b>		DATE SIGNED <b>5/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>White Haven Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>White Haven, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. S. Messick</b>		ADDRESS <b>Bivalve, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

# CERTIFICATE OF DEATH

Form No. 100-100

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1941	
NAME OF DECEASED [Faint Name]		SEX [Faint Sex]	
AGE [Faint Age]		RACE [Faint Race]	
PLACE OF BIRTH [Faint Place]		DATE OF BIRTH [Faint Date]	
OCCUPATION [Faint Occupation]		CAUSE OF DEATH [Faint Cause]	
PLACE OF DEATH [Faint Place]		TIME OF DEATH [Faint Time]	
SIGNATURE OF PHYSICIAN [Faint Signature]		SIGNATURE OF REGISTRAR [Faint Signature]	
CERTIFICATE NO. [Faint Number]		COUNTY [Faint County]	
CITY [Faint City]		STATE [Faint State]	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH.



6139

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>				d. STREET ADDRESS <u>1733 LaSalle Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>Macquoid</u> Last				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William J. Macquoid</u>				14. MOTHER'S MAIDEN NAME <u>Amanda McFarland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Scott Evans</u> Address <u>Norfolk Va.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 816X DUE TO <u>Arterio Sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Diabetes mellitus</u> (b) <u>Diabetes mellitus</u> (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (or 19). WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>Crushed chest - slight hemoptysis</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving auto - ran into back of car ahead</u>							
20c. TIME OF INJURY Hour <u>8</u> 6 m. <u>p.m.</u> Month, Day, Year <u>5-21 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 13</u>		20f. (City or town) <u>Wicomico</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>J. Wm. Lee's Sons</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Herman Purcell</u> ADDRESS <u>Anna Rd</u>				24a. REC'D BY REGISTRAR <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		W. J. B. B.	
AGE		35	
SEX		Male	
RACE		White	
DATE OF DEATH		1913	
PLACE OF DEATH		At home	
CAUSE OF DEATH		Heart disease	
MANNER OF DEATH		Natural	
SIGNATURE OF MEDICAL EXAMINER		[Signature]	
DATE OF EXAMINATION		1913	
PLACE OF EXAMINATION		At home	
SIGNATURE OF WITNESSES		[Signatures]	
DATE OF SIGNATURE		1913	
PLACE OF SIGNATURE		At home	
SIGNATURE OF REGISTRAR		[Signature]	
DATE OF SIGNATURE		1913	
PLACE OF SIGNATURE		At home	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6179 CERTIFICATE OF DEATH

Reg. Dist. No.

06144

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Fruitland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Center St</b>				d. STREET ADDRESS <b>Center St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>22</b> Year <b>59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1880</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>7</b> Days <b>9</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-Ship Yard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Repairman</b>		11. BIRTHPLACE (State or foreign country) <b>Eden, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>William George Martin</b>				14. MOTHER'S MAIDEN NAME <b>Martha Jane Messick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Adell L. Martin (Wife)</b> <b>Center St</b> <b>XXX Fruitland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.1 Curricular Fibrillation</b> DUE TO <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO <b>generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>o. m.</b> <b>19</b> Month <b>Day</b> <b>Year</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1950</b> , 19, to <b>5-22-1959</b> , that I last saw the deceased alive on <b>5-21-59</b> , 19, and that death occurred at <b>3:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DATE SIGNED</b> <b>Lee L. Lawry</b> <b>May 25 /1959</b> M.D. <b>Fruitland, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>May 25, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Clifford E. Brown</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6140

## CERTIFICATE OF DEATH

Reg. Dist. No.

06145

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1021 E. Main St</b>		d. STREET ADDRESS <b>1021 E. Main St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PEARL W. MATTHEWS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>1st</b> Year <b>19 59.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>10</b> Days <b>21</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia (Oak Hall)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Washington Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Ketty Wheelton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Fred W. Small (Daughter)</b>		Address <b>1021 E. Main St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension, Ch. Arteriosclerosis, Myocarditis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b></b> o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>
20f. (City or town) <b></b> (County) <b></b> (State) <b></b>			
21. I certify that I attended the deceased from <b>Jan. 12</b> , 19 <b>51</b> , to <b>May 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-1</b> , 19 <b>59</b> , and that death occurred at <b>4:10</b> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b>May 1 /1959</b>			
ACTUAL SIGNATURE <b>Philip A. Insley</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>		Main St. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Assawoman Meth. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Assawoman, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY, MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>MAY 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	





6141

## CERTIFICATE OF DEATH

Reg. Dist. No.

06146

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>MD.</u> COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>1601 S. Pine</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>L.</u> Last <u>McDaniel</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>male</u>	COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph McDaniel</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Skelton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mr. John McDaniel Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary artery sclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/5</u> , 19 <u>59</u> , to <u>5/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/5</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Matley</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>711 Camden Ave., Salisbury, Md 5/5/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. L. B. Wilson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilson</u>		24. REC'D BY REGISTRAR <u>Princess Anne</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>		DATE <u>MAY 11 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



## 6142 CERTIFICATE OF DEATH

Reg. Dist. No.

06147

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN City</u>				d. STREET ADDRESS <u>205 Wicomico St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>M.</u> Last <u>Milbourne</u>				4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 11, 1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		11. IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Albert Purnell</u>				14. MOTHER'S MAIDEN NAME <u>Annie Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-12-6392</u>			
17. INFORMANT <u>MR. John W. Milbourne</u>				Address <u>OCEAN City, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>Hypertensive Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>2 yrs 11 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>6-4</u> , 19 <u>56</u> , to <u>5-8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-8</u> , 19 <u>59</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin, Md</u>			
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. MD</u>				DATE SIGNED <u>5/9/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6143 Item 1. Film G242 5-15-59 mnd  
CERTIFICATE OF DEATH

06148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>SOMSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN TB <b>6 mo.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b> 1939.2		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Penninsula General Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lyda, G. MILES</b> First Middle Last		4. DATE OF DEATH <b>MAY 6 1959</b> Month Day Year	
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 5. 1889</b> 76 yrs.
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEA FOOD</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CRISFIELD, SOM, USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PRESTON, Jewett</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE, F. MILES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>SALISBURY</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO <b>Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of Liver</b> DUE TO <b>Unknown</b> (c) <b>Unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>few days</b> <b>UNK.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat. while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 24, 1959</b> to <b>May 6, 1959</b> , that I last saw the deceased alive on <b>May 5, 1959</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Herbert Sembly</b> M.D.		ADDRESS (Street, city or town, state) <b>400 E. Church St. Salisbury, Md.</b> DATE SIGNED <b>5/6/59</b>	
PHYSICIAN'S NAME (Type) <b>G. Herbert Sembly</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 9. 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LAWSONA</b>		22d. LOCATION (City, town, or county) (State) <b>CRISFIELD, SOM, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b> ADDRESS <b>Marion Sta,</b>		24a. REC'D BY REGISTRAR <b>MAY 13 '59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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CRISTFIELD, MD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6144 CERTIFICATE OF DEATH

Reg. Dist. No.

06149

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Park Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jerry Hurston Moore</b>				4. DATE OF DEATH Month Day Year <b>May 6th 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1959</b>	
9. AGE (In years last birthday) yrs. <b>1</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jerry Moore</b>				14. MOTHER'S MAIDEN NAME <b>Rose A. Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Jerry Moore, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Delmar</b>				20g. (County) <b>Delaware</b>		20h. (State) <b>Delaware</b>	
21. I certify that I attended the deceased from <b>May 5, 1959</b> , to <b>death</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/7, 1959</b> , and that death occurred at <b>9:30 p. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>100 Grove Street</b> DATE SIGNED <b>5/7/59</b>							
ACTUAL SIGNATURE <b>Ernest M. Larmore</b>				PHYSICIAN'S NAME (Type) <b>Ernest M. Larmore</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Careys Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Millsboro, Del.</b>				22e. (State) <b>Delaware</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Marvel Co. Delmar, Del.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06150

## 6145 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN IB <b>265 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastport</b>		d. STREET ADDRESS <b>321 Burnside</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Norfolk</b> Last <b>Norfolk</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1886</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Iron worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Friendship, Anne Arundel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sam Norfolk</b>		14. MOTHER'S MAIDEN NAME <b>Katie Trott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>206-01-0985</b>	
INFORMANT <b>Hospital Records, Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>029X Lues, intestinal carcinoma</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 3</b> , 19 <b>58</b> , to <b>May 26</b> , 19 <b>59</b> that I last saw the deceased alive on <b>May 26</b> , 19 <b>59</b> , and that death occurred at <b>6:35AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>5/26/59</b>			
ACTUAL SIGNATURE <b>G. Kosmahly</b>		M.D. <b>Deer's Head State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 29, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

00150

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6180 CERTIFICATE OF DEATH

06151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Shade Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Marie</b> Last <b>Owens</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Sussex County, Del</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George S. Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Gazie Hitch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>W. Hamilton Owens, Sharptown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BOWEL WITH METASTASIS</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CEREBRAL THROMBOSIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 7</b> , 19 <b>57</b> , to <b>May 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 16</b> , 19 <b>59</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>714 WEST ST.</b> DATE SIGNED <b>5/20/59</b> ACTUAL SIGNATURE <b>Joseph A. Elliott</b> M.D. PHYSICIAN'S NAME (Type) <b>JOSEPH A. ELLIOTT</b> <b>LAUREL DEL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Firemans</b>		22d. LOCATION (City, town, or county) (State) <b>Sharptown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles W. Marvel - Sharptown, Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6146 CERTIFICATE OF DEATH

06152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Lee</u> Last <u>PAINTER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lincoln Co., West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George McGee</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn May</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. John L. Adams, Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>1 year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/24</u> , 19 <u>59</u> , to <u>5/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/29</u> , 19 <u>59</u> , and that death occurred at <u>6:15</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>5/30/59</u> ACTUAL SIGNATURE <u>Harry Maltby</u> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Hurricane, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son, Federalsburg, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6147 CERTIFICATE OF DEATH

Reg. Dist. No.

06153

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>Parkinson</u> Last <u>Parkinson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-25-1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>27</u> Hours <u>19</u> Min. <u>59</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11c. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN PARKINSON</u>		14. MOTHER'S MAIDEN NAME <u>EMILY ABBOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>INA ADAMS - daughter - Wenona Md</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion, Acute</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Chronic Fibrosing Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Fibrosing Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/26</u> , 19 <u>59</u> , to <u>5/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>59</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. SALISBURY, Md.</u>	
DATE SIGNED <u>5/29/59</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 29-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's</u>		22d. LOCATION (City, town, or county) (State) <u>WENONA MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Webster</u> ADDRESS <u>Seal Island Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knecht</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6181 CERTIFICATE OF DEATH

06154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Pittsville (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 (At Home)</b>		d. STREET ADDRESS <b>R.D.# 1 (At Home)</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ANDREW</b> Last <b>PARSONS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> th <b>th</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 25, 1886</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Isaac W. Parsons</b>		14. MOTHER'S MAIDEN NAME <b>Mary Caroline Smack</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mrs. Alice Mae Parsons (Wife) R.D.#1 Pittsville, Maryland</b>	
17. INFORMANT <b>Mrs. Alice Mae Parsons (Wife) R.D.#1 Pittsville, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized pneumonia</b> 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>lung abscess</b> DUE TO (c) <b>Severe bronchiectasis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 week</b> <b>3-4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe anemia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year 19 p. m. 19			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 16, 1959</b> to <b>May 26, 1959</b> , that I last saw the deceased alive on <b>May 26, 1959</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>7 BAY ST., BERLIN, Md.</b> DATE SIGNED <b>5/27/59</b>			
ACTUAL SIGNATURE <b>Robert A. Grubb M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Robert A. Grubb</b> <b>Berlin, Maryland</b> <b>May 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 29, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery-R.D.# Pittsville, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> <b>SALISBURY MARYLAND</b>			
24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>			

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

NAME OF DECEASED  
AGE  
SEX  
RACE

DATE OF DEATH  
PLACE OF DEATH

CAUSE OF DEATH  
MANNER OF DEATH

DATE OF BIRTH  
PLACE OF BIRTH

EDUCATION  
OCCUPATION

RELIGION  
MARRIAGE

PREVIOUS ILLNESS  
PREVIOUS SURGERY

PREVIOUS TRAUMA  
PREVIOUS DRUGS

PREVIOUS ALCOHOL  
PREVIOUS TOBACCO

PREVIOUS OTHER  
PREVIOUS OTHER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G242 5-12-59 et

6182

CERTIFICATE OF DEATH

Reg. Dist. No.

06155

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.Church St.(P.O.B#153)</b>				d. STREET ADDRESS <b>E.Church St.(P.O.B.#153)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>E.</b> Last <b>PARSONS</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov.28,1892</b>	
9. AGE (In years last birthday) <b>67 66</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.		IF UNDER 24 HRS. Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.		IF UNDER 59 HRS. Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee-Campbell Soup Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Salisbury, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>(Unk)</b>			
14. MOTHER'S MAIDEN NAME <b>Rose Parsons</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, up or unknown) <b>Unk</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>Unk</b>				17. INFORMANT <b>Mrs. Margie E. Parsons (Wife) E.Church St (P.O.B.#153) Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of blood - metastases</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12-10</b> , 19 <b>58</b> , to <b>2-26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury Md.</b> DATE SIGNED <b>May 4 /1959</b> ACTUAL SIGNATURE <b>W. H. Fisher</b> M.D. <b>Salisbury Md.</b> PHYSICIAN'S NAME (Type) <b>Dr. William H. Fisher</b> <b>Medical Center - Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>May 5, 1959</b>		<b>Wicomico Memorial Park</b>		<b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rouse</b>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
Reg. Dist. No. 06156																			
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Accomac</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chincoteague</b> <b>83x-3</b> ✓									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen Hospital</b>					d. STREET ADDRESS <b>105 Smith St</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>Henry</b> Last <b>PITTS</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>26th</b> Year <b>1959</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 15 1940</b>		9. AGE (In years this birthday) <b>18</b> yrs.		IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>High School</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Long Island N.Y.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Henry Pitts</b>					14. MOTHER'S MAIDEN NAME <b>Minnie Doty</b>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>230-50-3674</b>					17. INFORMANT <b>Henry Pitts, Chincoteague, Va.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>825X</b> <b>Subdural hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>None</b> DUE TO (c) <b>None</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>None</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Injured in auto accident.</b>														
20c. TIME OF INJURY Hour <b>2 A.M.</b> m. <b>15</b> p.m. <b>15</b> Month, Day, Year <b>5-23-59</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>					20f. (City or town) <b>Chincoteague</b> (County) <b>Accomac</b> (State) <b>Va.</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Earl L. Royer</b>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>May 28 1959</b>				
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>May 31, 1959</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Downing Cemetery</b>					22d. LOCATION (City, town, or county) <b>Oak Hall, Virginia</b> (State) <b>Va.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>										24a. REC'D BY REGISTRAR <b>JUN 4 59</b> DATE					24b. REGISTRAR'S SIGNATURE <b>Carleton S. Hines</b>				



## 6149 CERTIFICATE OF DEATH

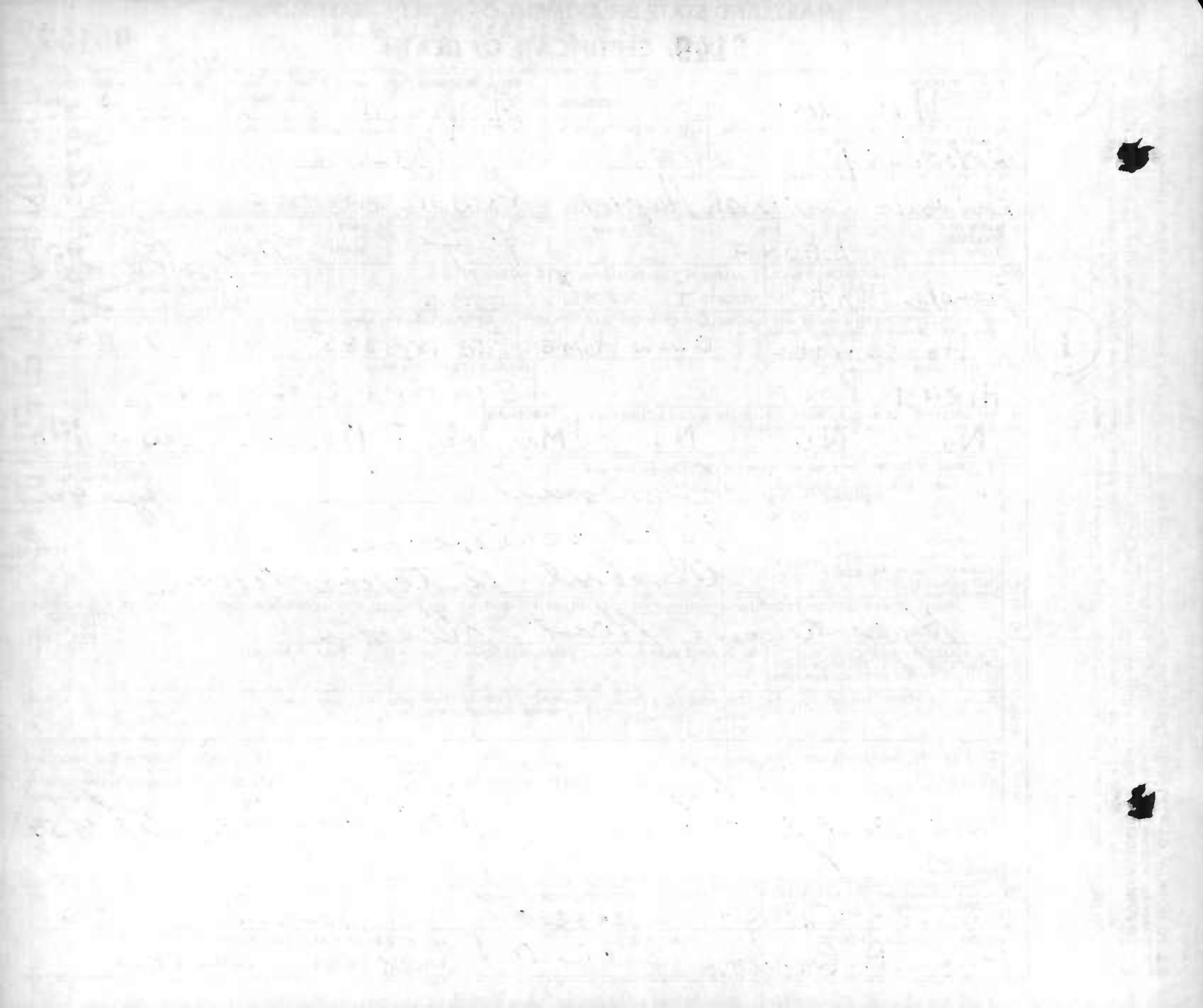
Reg. Dist. No.

06157

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>POWELLTON AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAUNA</u> <u>Post</u>		4. DATE OF DEATH Month Day Year <u>May</u> <u>13</u> <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>approx.</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>FEB. 18, 1885</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HIRAM POST</u>		14. MOTHER'S MAIDEN NAME <u>STATIRA COOKMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MR. JOHN T. BRUEHL, BERLIN MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X Anemia</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx 4 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:45</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilman</u>		DATE SIGNED <u>5/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Barbage</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 18 '59</u>	
ADDRESS <u>Berlin Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6150 CERTIFICATE OF DEATH

Reg. Dist. No.

06158

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hallwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>				d. STREET ADDRESS <u>83X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>J.</u> Last <u>Poulson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 6, 1893</u>	
9. AGE (In years lost birthday) <u>65</u> yrs.		10. UNDER 1 YEAR <u>4</u> Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Massville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Artemus Poulson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Northam</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>230-05-4124</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UR EMIA</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA BLADDER</u> DUE TO (c)				INTERVAL BETWEEN DEATH AND DEATH <u>3 WEEKS</u> <u>2 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/1</u> , 1958, to <u>5/1</u> , 1959, that I last saw the deceased alive on <u>5/1</u> , 1959, and that death occurred at <u>3:05</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John M. Blocker, Jr.</u>				ADDRESS (Street, city or town, state) <u>Marion Center, Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOCKER, JR.</u>				DATE SIGNED <u>5/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/3/59</u>		<u>Graves</u>		<u>Hallwood Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Richard Johnson, Pockley Va</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6151 CERTIFICATE OF DEATH

Reg. Dist. No.

06159

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL</u>		d. STREET ADDRESS <u>PHILADELPHIA AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES SAMUEL POWELL</u>		4. DATE OF DEATH Month Day Year <u>MAY 20<sup>th</sup> 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 15, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM POWELL</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SHACK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MR CHARLES HOLLOWAY</u>		Address <u>OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Adenocarcinoma of prostate</u> DUE TO <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral submaxillary gland abscess</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u> <u>6 mos.</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>May 20</u> , 1959, that I last saw the deceased alive on <u>May 20<sup>th</sup></u> , 1959, and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond M. Gyor</u> M.D.		ADDRESS (Street, city or town, state) <u>707 Camden Ave</u> DATE SIGNED <u>5/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knaus</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>	
ADDRESS <u>Berlin Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH	
FATHER'S NAME		MOTHER'S NAME		MARRIAGE		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		SYMPTOMS		DIAGNOSIS		PROGNOSIS		MEDICATION		SURGERY	
TESTIMONY OF PHYSICIAN		TESTIMONY OF WITNESSES		TESTIMONY OF FUNERAL HOME		TESTIMONY OF CORONER		TESTIMONY OF JURY		TESTIMONY OF COURT		TESTIMONY OF STATE		TESTIMONY OF FEDERAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF COURT		SIGNATURE OF STATE		SIGNATURE OF FEDERAL	
DATE		TIME		LOCATION		OFFICE		DEPARTMENT		DIVISION		SECTION		UNIT	

RECEIVED  
JAN 10 1924  
BOSTON

MASSACHUSETTS  
STATE DEPARTMENT OF HEALTH



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>David Thomas Pusey</b>				4. DATE OF DEATH Month Day Year <b>5- 5- 19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-1884</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Pusey</b>				14. MOTHER'S MAIDEN NAME <b>Annie Quillin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Emma Pusey, Sharptown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio-sclerotic cardio-vascular disease</b> (c), stating the underlying cause last. DUE TO <b>Years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Sharptown, Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.				DATE SIGNED <b>5-6-59</b>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<b>Burial</b>	<b>5-10-59</b>	<b>Firemans</b>		<b>Sharptown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. [Signature]</b> ADDRESS <b>Sharptown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>	

MEDICAL CERTIFICATION

2





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6152 CERTIFICATE OF DEATH

Reg. Dist. No.

06161

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>207 Tilghman St</b>				d. STREET ADDRESS <b>207 Tilghman St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>TAYLOR</b> Last <b>PUSEY</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> ST <b>19</b> Year <b>59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27, 1904</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>24</b> Hours <b></b> Min. <b></b>		11. BIRTHPLACE (State or foreign country) <b>R.D.# Princess Anne Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi</b>		11. BIRTHPLACE (State or foreign country) <b>R.D.# Princess Anne Md.</b>	
13. FATHER'S NAME <b>Edgar Elzie Pusey</b>				14. MOTHER'S MAIDEN NAME <b>Anna Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mrs. Lyda Pusey (Wife) 207 Tilghman St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> (b) <b></b> (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1936</b> to <b>May 21, 1959</b> , that I last saw the deceased alive on <b>May 4, 1959</b> , and that death occurred at <b>5:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>334 Camden Ave. Salisbury, Maryland</b> DATE SIGNED <b>May 24/59</b>							
ACTUAL SIGNATURE <b>William D. Gray</b>				M.D. <b>334 Camden Ave. Salisbury, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Dr. William D. Gray</b>				M.D. <b>334 Camden Ave. Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 24, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 26 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06162	
tem 18 Film 243 6-16-59 ams											
6153 CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Worcester</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23x-2</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRUCE EDWARD RICKARDS</u>					4. DATE OF DEATH Month Day Year <u>MAY 15th 1959</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 31 1958</u>		9. AGE (In years last birthday) yrs. <u>-</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ronald Richard</u>					14. MOTHER'S MAIDEN NAME <u>NORMA LEE WAINWRIGHT</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>MR. NORMAN WAINWRIGHT BERLIN MD</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute hemorrhagic interstitial pneumonia</u> <u>492X</u> DUE TO <u>TRUNCATED INFECTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>viral disease of unknown etiology</u> DUE TO <u>1. (Autopsy) 2. (Autopsy) 3. (Autopsy) 4. (Autopsy) 5. (Autopsy) 6. (Autopsy) 7. (Autopsy) 8. (Autopsy) 9. (Autopsy) 10. (Autopsy) 11. (Autopsy) 12. (Autopsy) 13. (Autopsy) 14. (Autopsy) 15. (Autopsy) 16. (Autopsy) 17. (Autopsy) 18. (Autopsy) 19. (Autopsy) 20. (Autopsy) 21. (Autopsy) 22. (Autopsy) 23. (Autopsy) 24. (Autopsy) 25. (Autopsy) 26. (Autopsy) 27. (Autopsy) 28. (Autopsy) 29. (Autopsy) 30. (Autopsy) 31. (Autopsy) 32. (Autopsy) 33. (Autopsy) 34. (Autopsy) 35. (Autopsy) 36. (Autopsy) 37. (Autopsy) 38. (Autopsy) 39. (Autopsy) 40. (Autopsy) 41. (Autopsy) 42. (Autopsy) 43. (Autopsy) 44. (Autopsy) 45. (Autopsy) 46. 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STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

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61547 CERTIFICATE OF DEATH

06163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.D.#4</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE HARRY ROBERTSON</u>				4. DATE OF DEATH Month Day Year <u>MAY 30 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jun. 6, 1884</u>	9. AGE (In years last birthday) yrs. <u>74</u>	IF UNDER 1 YEAR Months Day Hours Min. <u>11 24</u>	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer &amp; Lumberman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>White Haven, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>George Henry Robertson</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Ellen White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Matilda W. Robertson (Wife) R.D.# 4 Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Hypertensive Cardiovascular Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with Nephrosclerosis and Arteriosclerosis.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 1959, to <u>May 30</u> , 1959, that I last saw the deceased alive on <u>May 29</u> , 1959, and that death occurred at <u>6:24</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury Md.</u>		DATE SIGNED <u>5/30/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jun. 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

Form 100-1

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	



6155

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Life Time</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elton</u> Middle <u>George</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>G</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>I/12/1907</u>
9. AGE (In years last birthday) <u>52 5/3</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U A S</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Stella Dashiels</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Stella Bevins.Princess Anne,Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of skull and brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>981X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in back of head by Preston Corbin</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:20 p.m. 5-11-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R F D # 3</u>		20f. (City or town) (County) (State) <u>Princess Ann Somerset Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>5-18-59</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary</u>	22d. LOCATION (City, town, or county) (State) <u>West Post Office, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr</u>		ADDRESS <u>Princess Anne, Md</u>	
24a. REC'D BY REGISTRAR <u>MAY 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6156

## CERTIFICATE OF DEATH

06165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Riverside Nursing Home</b>				e. STREET ADDRESS <b>709 E. Isabella St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FRANCIS</b> Last <b>SIMMS</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1859</b>		9. AGE (In years last birthday) <b>99</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Fruit Dealer-Produce</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Jesse Simms</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Cantwell</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>			16. SOCIAL SECURITY NO. <b>Mr Thomas N. Simms (Nephew) R.D. # 1 Salisbury, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> <b>Arterio-sclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>4/7</b> , 19 <b>58</b> , to <b>5/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/27</b> , 19 <b>59</b> , and that death occurred at <b>3:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. L. Gramse</b>			M.D. <b>Salisbury, Md</b>		DATE SIGNED <b>May 28 / 1959</b>		
PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b>			ADDRESS (Street, city or town, state) <b>S. Division St. Salisbury, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 30, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>			ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Location: [illegible] [illegible] [illegible]

Sub: [illegible]

Ref: [illegible]

Project: [illegible] [illegible] [illegible]

Job: [illegible] [illegible] [illegible]

Date: [illegible] [illegible] [illegible]

By: [illegible] [illegible] [illegible]

For: [illegible] [illegible] [illegible]

Project Manager: [illegible] [illegible] [illegible]

[illegible signature]

X

7-8-1955

Approved: [illegible] [illegible] [illegible]

Special Day: [illegible] [illegible] [illegible]

HOLWAY & COMPANY, BELLINGHAM, WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06166

## 6184 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>S. Division St. Ext.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>SMULLEN</b> Last <b>SMULLEN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>2nd</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR <b>4</b> Months <b>12</b> Days	11. IF UNDER 24 HRS. <b>4</b> Hours <b>12</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Eden Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Wesley Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Indiana Hopkins</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Mildred Parsons (Daughter) S. Div. St. Ext. Fruitland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x Cardio-Vascular Recrud Disease</b> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1954</b> 19____ to <b>death</b> 19____, that I last saw the deceased alive on <b>May 1st, 1959</b> , and that death occurred at <b>5:50A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lee L Lawry</b> M.D.		ADDRESS (Street, city or town, state) <b>May. 4th 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry</b>		<b>Fruitland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 4/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Smullen Cemetery -St. Luke-Near Fruitland, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>MAY 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6157

## CERTIFICATE OF DEATH

Reg. Dist. No.

06167

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Annes</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>5 Yrs. 8 Mo. 24 Days</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Queenstown</b>		d. STREET ADDRESS <b>17X-2</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Hopper</b> Last <b>Stant</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1877</b>	
9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Centreville, Md</b>		
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>William Stant</b>		14. MOTHER'S MAIDEN NAME <b>Susie Smith</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		
17. INFORMANT <b>Hospital Records - Salisbury, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerosis General</b>				INTERVAL BETWEEN ONSET AND DEATH <b>30 Hours</b> <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>8-31-53</b> to <b>5/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/24</b> , 19 <b>59</b> , and that death occurred at <b>11.40A</b> M, from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>V. Juerman</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>		
DATE SIGNED <b>5/24/59</b>				
PHYSICIAN'S NAME (Type) <b>Verner Juerman,</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/26/59</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Centreville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Centreville Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane Church Hill.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 28 '59</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				



6158

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle Last <u>Stein</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1911</u>	
9. AGE (In years lost birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Products</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Hyman Stein</u>				14. MOTHER'S MAIDEN NAME <u>Celia Dinkelis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>***** 165-10-2059</u>			
17. INFORMANT <u>Mrs. Mary P. Stein</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bronchogenic carcinoma</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>December</u> , 19 <u>58</u> , to <u>May 11</u> , 19 <u>59</u> that I last saw the deceased alive on <u>May 11</u> , 19 <u>59</u> , and that death occurred at <u>9:00</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry Mattax</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>5/11/59</u>	
PHYSICIAN'S NAME (Type) <u>HARRY MATTAX M.D.</u>				<u>SALISBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Montefiore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co., Salisbury, Maryland</u>				ADDRESS <u>Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TELETYPE

URGENT

TO DIRECTOR

FROM SAC, NEW YORK

U.S.A.

RE NEW YORK

TELETYPE

URGENT

TO DIRECTOR

FROM SAC, NEW YORK

U.S.A.

RE NEW YORK

TELETYPE

URGENT

RECEIVED

TELETYPE

URGENT

RE NEW YORK

TO DIRECTOR

FROM SAC, NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6159 CERTIFICATE OF DEATH

Reg. Dist. No. 06169

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkesley</u> 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>83x-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Julius</u> Last <u>Sterling</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1905</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomack</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Sterling</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Masow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Doris E Sterling Parkesley, Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of prostate with</u> <u>177x</u> DUE TO <u>multiple metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>18 mos.</u> DUE TO (c) <u>18 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 1957, to <u>MAY 14</u> , 1959, that I lost the deceased alive on <u>May 14</u> , 1959, and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond M. Your</u>		ADDRESS (Street, city or town, state) <u>707 Camden, Salisbury, Md 21804</u>	
DATE SIGNED <u>May 14, 1959</u>		DATE SIGNED <u>May 14, 1959</u>	
PHYSICIAN'S NAME (Type) <u>J. Richard Johnson</u>		ADDRESS <u>Parkesley, Va.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkesley</u>		22d. LOCATION (City, town, or county) (State) <u>Parkesley Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Richard Johnson</u>		ADDRESS <u>Parkesley, Va.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

00100

6128 CERTIFICATE OF BIRTH

W. S. ...  
...  
...

Paul ...  
...  
...

James ...  
...  
...

...

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...

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00100



6160 CERTIFICATE OF DEATH

06170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>23x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>NEWARK</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAZEL TOWNSEND TAYLOR</u>		4. DATE OF DEATH Month Day Year <u>MAY 21 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 3, 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MDRD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>FRANK TOWNSEND</u>		14. MOTHER'S MAIDEN NAME <u>ALINE DENNIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-24-2918</u>	
17. INFORMANT <u>MR. MILTON DENNIS</u>		Address <u>NEWARK MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/14</u> , 19 <u>59</u> , to <u>5/21</u> , 19 <u>59</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md</u> <u>5-21-59</u>			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.			
PHYSICIAN'S NAME (Type) <u>William R. Ellis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOWEN CEMETARY</u>	22d. LOCATION (City, town, or county) (State) <u>NEWARK MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burboye</u>		ADDRESS <u>Bulim Md</u>	24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



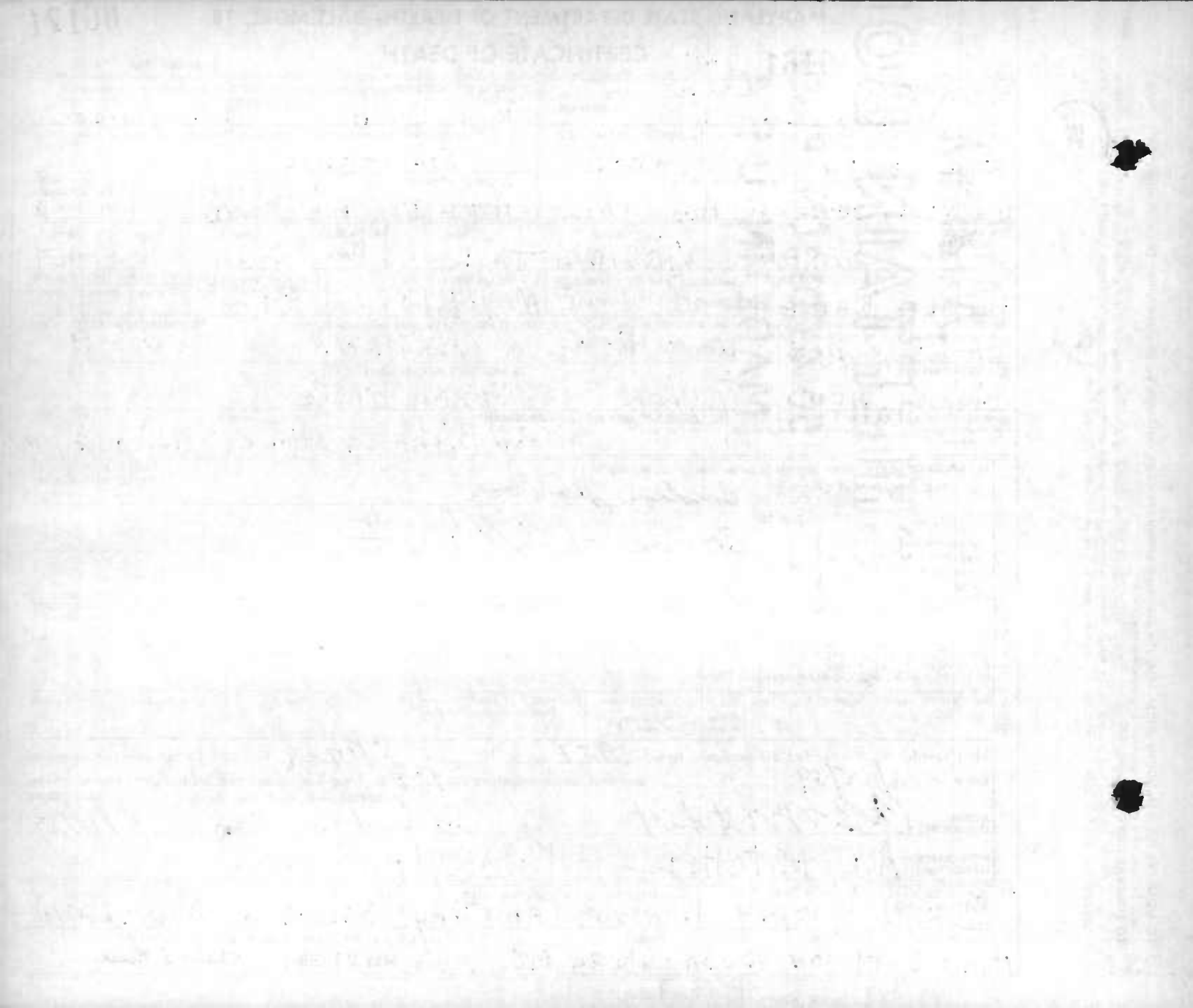
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6161  
6161  
CERIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>309 Newton Street</u> <u>HOME/APP/TH/ACED</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH VIRGINIA TAYLOR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 14, 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Sarah White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>John B. PARSONS Home. SALISBURY, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>170 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of left breast</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> to <u>5/18/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/18/59</u> , 19 <u>59</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Mitchell</u> M.D. <u>Salisbury MD</u>		DATE SIGNED <u>5/18/59</u>	
PHYSICIAN'S NAME (Type) <u>A.C. MITCHELL 211 MARYLAND AVE.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill + JOHNSON CO. SALISBURY, MD</u> <u>Norman F. Baker</u>		24. REC'D BY REGISTRAR <u>MAY 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6162 CERTIFICATE OF DEATH

06172

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Wicomico</i> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury - Md</i>	
c. LENGTH OF STAY IN 1b <i>1 mo.</i>		d. STREET ADDRESS <i>1 Kelly Drive R.D. 5</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <i>Raymond Lewis Thomas</i>		<b>4. DATE OF DEATH</b> Month Day Year <i>May 25 1959</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 23, 1915</i>	
9. AGE (In years last birthday) <i>43</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>	
11. BIRTHPLACE (State or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Raymond D. Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Brittingham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>222-09-3452</i>	
17. INFORMANT <i>Alice Branne</i>		Address <i>Salisbury, Md.</i>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of the urethra</i> 181.7 DUE TO <i>with multiple metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October</i> , 1959, to <i>May 25</i> , 1959, that I last saw the deceased alive on <i>May 25</i> , 1959, and that death occurred at <i>8 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Raymond M. Gaur</i>		ADDRESS (Street, city or town, state) <i>707 Camden Ave Salisbury, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Raymond M. Gaur</i>		DATE SIGNED <i>5/25/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/28/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Rest Men's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Delaware - Del.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ronald James Millshon</i>		ADDRESS <i>Del</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 1 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23x-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>210 E. Martin Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Bara</u> Middle <u>Tilghman</u> Last <u>Tilghman</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20-1883</u>	
9. AGE (In years last birthday) <u>75 5/8</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>md</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Annie Garbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>102-266293</u>		17. INFORMANT <u>Mrs. Nell O. Jones</u> Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u> DUE TO (b) <u>intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>6 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>199.2</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>59</u> , to <u>May 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 28</u> , 19 <u>59</u> , and that death occurred at <u>10:30 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>May 28, 1959</u>							
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u> M.D.				DATE SIGNED <u>May 28, 1959</u>			
PHYSICIAN'S NAME (Type) <u>William H. Fisher Jr.</u>				Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 31/59</u>		<u>St. Luke's Chapel Cemetery</u>		<u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Dennis</u>				ADDRESS <u>Snow Hill, md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>							

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

DECEASED  
IN  
CITY OF  
ALBANY  
ON  
MAY 10 1900  
AT  
AGE 45  
YEARS  
MARRIED  
15  
YEARS  
TO  
MRS. J. H. BROWN  
OF  
ALBANY  
N. Y.

Signature

Attest: J. H. BROWN

Name of Deceased		Date of Death	
J. H. BROWN		MAY 10 1900	
Place of Birth		Date of Birth	
ALBANY, N. Y.		MAY 15 1855	
Cause of Death		Duration of Illness	
HEART DISEASE		10 DAYS	
Signature of Physician		Signature of Registrar	
J. H. BROWN		J. H. BROWN	
Signature of Coroner		Signature of Burial Officer	
J. H. BROWN		J. H. BROWN	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6164

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>R.D.# 5</b>	
3. NAME OF DECEASED (Type or print) First <b>DEBRA</b> Middle <b>LYNN</b> Last <b>TOADVINE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>29th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1958</b>
9. AGE (In years last birthday) <b>0</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>26</b>	11. IF UNDER 24 HRS. Hours <b>26</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Theodore Albert Toadvine</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Laird</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Theodore A. Toadvine (Father) R.D.#5 Salisbury, Maryland</b>	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to aspirated vomitus</b> DUE TO <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (b) <b>921.0</b> (c), stating the underlying cause lost. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Child choked suddenly at play.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:40 P.M. 5-29-59</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Own Home</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		DATE SIGNED <b>June 1 /1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jun. 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

MEDICAL CERTIFICATION



6165

CERTIFICATE OF DEATH

06175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1 Naylor Mill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TRADER</u>				4. DATE OF DEATH Month Day Year <u>MAY 4 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 3 1959</u>	
9. AGE (In years lost birthday) yrs. <u>20</u>		IF UNDER 1 YEAR Months Days Hours Min <u>20 24</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTH PLACE (State or foreign country) <u>Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Vaughn Trader</u>				14. MOTHER'S MAIDEN NAME <u>Synthia Salzer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.5</u> DUE TO <u>atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/3</u> , 19 <u>59</u> , to <u>5/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/4</u> , 19 <u>59</u> , and that death occurred at <u>4:15</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury Md 5/4/59</u>							
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.				PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blaschke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Parsonburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



10173 10173 10173 10173 10173 10173 10173 10173 10173 10173



10173 10173 10173 10173 10173 10173 10173 10173 10173 10173



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6185 CERTIFICATE OF DEATH

Reg. Dist. No.

06176

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Wicomico</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MINNIE</u> Middle <u>M.</u> Last <u>TURNER</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Rodney Turner, Jesterville, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 Feb., 1947</u> to <u>13 May, 1959</u> , that I last saw the deceased alive on <u>13 May 1959</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.		ADDRESS (Street, city or town, state) <u>Nanticoke, Maryland</u>		DATE SIGNED <u>5/17/59</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>		<u>Nanticoke, Maryland 5/16/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Jesterville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Thomas</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6166

CERTIFICATE OF DEATH

06177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Peninsula General Hospital</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Walker</u> Last <u>Walker</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>May 10, 1884</u>		9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Walker</u>				14. MOTHER'S MAIDEN NAME <u>Harriot Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Mattie Walker, Tanger St. Salisbury Md.</u> Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Unk.</u> INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>	
20f. (City or town) <u>Salisbury</u> (County) <u>_____</u> (State) <u>_____</u>							
21. I certify that I attended the deceased from <u>May 11, 1959</u> to <u>May 24, 1959</u> , that I last saw the deceased alive on <u>May 23, 1959</u> , and that death occurred at <u>9:22 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembly</u> M.D.				ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>				DATE SIGNED <u>5/25/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green acers</u>	
22d. LOCATION (City, town, or county) <u>Salisbury Md.</u> (State) <u>_____</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u> ADDRESS <u>Salis - Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 2 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Thomas</u>	



## 6186 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Sharptown</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Shade Convelescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOTTIE</b> Middle <b>H.</b> Last <b>WALKER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24,</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 18, 1878</b>
9. AGE (In years lost birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Robert Davis</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Helsby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-28-1542D</b>	
17. INFORMANT <b>Mrs. Teaford Leonard</b>		Address <b>Easton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>571.1</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 week.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease - See Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/27</b> , 19 <b>59</b> , to <b>5/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/23/59</b> , 19 <b>59</b> , and that death occurred at <b>6:00 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. S. Kuhlman</b> M.D.		ADDRESS (Street, city or town, state) <b>Sharptown Md</b> DATE SIGNED <b>5/26/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H. S. Kuhlman</b>		<b>Sharptown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 26, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		ADDRESS <b>Easton, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. HARRIS</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 6167 CERTIFICATE OF DEATH

06179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Zion Road (R.D.# 5)</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>THOMAS</u> Last <u>Watson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Retired - Saw Mill Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill Worker</u>		11. BIRTHPLACE (State or foreign country) <u>Assateague, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>James Watson</u>				14. MOTHER'S MAIDEN NAME <u>Mahala Archie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				18. SOCIAL SECURITY NO. <u>Mrs. Estelle Nichols (Daughter) R.D.#5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Hypostatic pneumonia (infective)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe atherosclerotic cardiovascular disease</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic hemorrhagic cystitis; grossly enlarged prostate</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury</u>				20g. (County) <u>Wicomico</u>		20h. (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>3/15/1959</u> to <u>5/2/1959</u> , that I last saw the deceased alive on <u>5/2/1959</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>  </u>			
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>May 3rd, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Dr. O.J. Burton</u>				<u>Maryland Ave. Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 6, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Holly Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Onancock, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>  </u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>				DATE <u>MAY 6 '59</u>		<u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

6168 CERTIFICATE OF DEATH

Reg. Dist. No. 06180

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fruitland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>213 Morris St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROGER</u> Middle <u>Williams</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>1st</u> Year <u>1959</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-1958</u>			
9. AGE (In years lost birthday) yrs. <u>8</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>26</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Robert Gowan</u>				14. MOTHER'S MAIDEN NAME <u>Emma Jean Williams</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u></u>					
17. INFORMANT <u>Miss. Emma Williams, Fruitland, Md</u>				Address <u></u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Endocardial Fibroelastosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>4/30</u> , 1959, to <u>5/1</u> , 1959, that I last saw the deceased alive on <u>5/1</u> , 1959, and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>5/4/59</u>									
ACTUAL SIGNATURE <u>William C. Morgan</u>				M.D. <u>Salisbury, Md</u>					
PHYSICIAN'S NAME (Type) <u></u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart Funeral Home, Salisbury, Md.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hanna</u>			
24b. REGISTRAR'S SIGNATURE <u></u>				DATE <u>MAY 8 '59</u>					

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CERTIFICATE OF DEATH

UNITED STATES



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## 6169 CERTIFICATE OF DEATH

06181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>DEAL ISLAND 19X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 13-1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAFOOD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL WILSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH CRABBE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>222-01-9118</u>	
17. INFORMANT Address <u>ADDIE WILSON - DEAL ISLAND MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure and Severe Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Widespread Metastases</u> DUE TO (c) <u>Cancer of the Stomach</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 6, 1959</u> to <u>May 17, 1959</u> that I last saw the deceased alive on <u>May 17, 1959</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carrie I Hearn</u> M.D.		ADDRESS (Street, city or town, state) <u>226 N. Main St Salisbury, Md</u>	
DATE SIGNED <u>May 21 '59</u>			
PHYSICIAN'S NAME (Type) <u>CARL E. HEARN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/21/59</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>JOHN WESLEY</u>	22d. LOCATION (City, town, or county) (State) <u>Deal Island Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u>		ADDRESS <u>Deal Island Md</u>	
24a. REC'D BY REGISTRAR <u>May 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie I Hearn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6170 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>203 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>Patrick Avenue; Rt. # 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>James</b>		Middle <b>Wilson</b>		Last <b>Wilson</b>	
4. DATE OF DEATH Month <b>May</b>		Day <b>4</b>		Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/12/1881</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b>		IF UNDER 24 HRS. Days <b>77</b>		Hours <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>422.1</b> DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>Arteriosclerosis, general</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b> INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b> <b>?</b> <b>?</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 13, 1958</b> , to <b>May 4, 1959</b> , that I last saw the deceased alive on <b>May 4, 1959</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>5/5/59</b>							
ACTUAL SIGNATURE <b>S. J. Juerman</b>		M.D. <b>Deer's Head State Hospital</b>					
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		<b>Salisbury, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>		22b. DATE THEREOF <b>5-7-59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Deer's Head State Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Booker M. Clark</b>				ADDRESS <b>Deer's Head State Hospital</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

1915

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RECEIVED

## 6187. CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>W. Church St</b>		d. STREET ADDRESS <b>W. Church St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>ELLEN</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>31</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Sussex Co. Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Davis Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Allie Hearn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>Mr. Upton D. Wilson (Son) Hebron, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arteriosclerosis</b> DUE TO (c) <b>Hypostatic Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>57 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 May, 1959</b> to <b>31 May, 1959</b> that I last saw the deceased alive on <b>31 May, 1959</b> , and that death occurred at <b>1300 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Hebron, Md.</b> DATE SIGNED <b>June 1 / 1959</b>	
ACTUAL SIGNATURE <b>Richard H. Saunders</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Richard H. Saunders</b>		<b>Hebron, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jun. 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hebron, Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hebron, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUN 2 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hearn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2121 CERTIFICATE OF DEATH

M

1939

Alcoholic  
Hepatitis

Hepatitis  
Hepatitis

Alcoholic

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

John W. Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6171 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06184  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>R.D.# 4</b>	
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>MARIE</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1916</b>
9. AGE (in years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>21</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Ernest White</b>	
14. MOTHER'S MAIDEN NAME <b>Ida Mae Ellingsworth</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Mr. Everett L. Wilson (Husband)</b>		17. INFORMATION <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Skull</b> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>3</b> o. m. <b>5-17</b> p. m. <b>1959</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <b>Route 50</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wicomico, Md</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Philip A. Insley</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Boyer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>May 18 /1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 20, 1959</b>	
22c. NAME OF BURIAL OR CREMATION LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>MAY 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

